



CICS

Supporting Individuals. Strengthening Communities.

Central Iowa Community Services
Boone • Franklin • Greene • Hamilton • Hardin • Jasper
Madison • Marshall • Poweshiek • Story • Warren
www.CICSMHDS.org

RELEASE OF INFORMATION

CLIENT: _____ STATE ID #: _____

ADDRESS: _____ DATE OF BIRTH: _____

I, the undersigned, hereby authorize the staff of Central Iowa Community Services to release and /or obtain the information indicated below, regarding the above named consumer, with:

Name of Person or Agency

Complete Mailing Address

The information being released will be used for the following purpose:

- | | |
|--|---|
| <input type="checkbox"/> Planning and implementation of services | <input type="checkbox"/> Referral for new or other services |
| <input type="checkbox"/> Coordination of services | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Monitoring of services | |

Your eligibility for services or funding is is not dependent upon signing this release. {See CFR 164.508(b)(4)}

INFORMATION TO BE RELEASED FROM CENTRAL IOWA COMMUNITY SERVICES:

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | SOCIAL HISTORY |
| <input type="checkbox"/> | <input type="checkbox"/> | PROGRESS SUMMARY REPORT |
| <input type="checkbox"/> | <input type="checkbox"/> | INDIVIDUAL COMPREHENSIVE PLAN |
| <input type="checkbox"/> | <input type="checkbox"/> | ANNUAL REVIEW |
| <input type="checkbox"/> | <input type="checkbox"/> | DISCHARGE SUMMARY |
| <input type="checkbox"/> | <input type="checkbox"/> | INFORMATION THAT YOU HAVE GIVEN CICS WRITTEN PERMISSION TO RECEIVE |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER (Specify) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER (Specify) _____ |

INFORMATION TO BE OBTAINED FROM THE AGENCY INDICATED ABOVE:

- | Yes | No | |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | SOCIAL HISTORY |
| <input type="checkbox"/> | <input type="checkbox"/> | EDUCATIONAL/VOCATIONAL PLANS |
| <input type="checkbox"/> | <input type="checkbox"/> | PROGRESS SUMMARY |
| <input type="checkbox"/> | <input type="checkbox"/> | PSYCHOLOGICAL EVALUATION/REPORTS |
| <input type="checkbox"/> | <input type="checkbox"/> | PSYCHIATRIC ASSESSMENT/REPORTS |
| <input type="checkbox"/> | <input type="checkbox"/> | MEDICAL HISTORY |
| <input type="checkbox"/> | <input type="checkbox"/> | TREATMENT PLAN |
| <input type="checkbox"/> | <input type="checkbox"/> | DISCHARGE SUMMARY |
| <input type="checkbox"/> | <input type="checkbox"/> | FINANCIAL DOCUMENTATION |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER (Specify) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER (Specify) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER (Specify) _____ |

This authorization shall expire on: _____. If no date is listed, the release is good for one year from date of signing.

At that time, no express revocation shall be needed to terminate my consent. I understand that this consent is voluntary and I may revoke this consent at any time by sending a written notice to Central Iowa Community Services. I understand that any information released prior to the revocation may be used for the purposes listed above and does not constitute a breach of my rights to confidentiality. I understand that any disclosure of information carries with it the potential for un-authorized re-disclosure and once the information is disclosed, it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information by contacting the recipient named or Central Iowa Community Services.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:

I specifically authorize the release of data and information relating to Mental Health.

Signature of Client or Legal Guardian: _____ Date: _____

Relationship if NOT The Client

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAWS:

I specifically authorize the release of data and information relating to:

- | | |
|--|--|
| <input type="checkbox"/> Substance Abuse (must be signed by the consumer) NOTE: Information protected by the Federal confidentiality law (42 CFR Part 2) will not be disclosed. | <input type="checkbox"/> HIV-Related Information |
|--|--|

Client Signature _____ Date _____ Guardian Signature _____ Date _____

In order for substance abuse and/or HIV-related information to be released, you must sign here and on the signature line above.